

**Statement of
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Before the

**U.S. Senate Committee on Finance
Physician Payment Roundtable
*“Medicare Physician Payment Policy:
Lessons from the Private Sector”***

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10:00 a.m.**

Chairman Baucus, Ranking Member Hatch, and other members of the Senate Finance Committee, thank you for providing me with this opportunity to discuss the steps CareFirst is taking to fundamentally change the way health care is delivered and reimbursed in the future. For the record, my name is Chet Burrell and I am President and CEO of CareFirst BlueCross BlueShield, a not-for-profit health care company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to nearly 3.4 million individuals and groups in Maryland, the District of Columbia and Northern Virginia – including, I am proud to say, a significant number of the Senators and members of their staffs here today.

CareFirst's Patient-Centered Medical Home (PCMH) is an innovative program designed to provide primary care providers with new incentives and tools to provide higher quality, lower cost care to our members. Our PCMH program is a model that is easily scalable as it is moving the region toward a new health care financing model that uses the incentives inherent in a global capitation model to counteract the volume-inducing aspects of fee for service, but without shifting risk to PCPs who are not in a position to assume those risks. Panels that produce a savings against their total global cost-of-care target share in the savings they generate based on savings, quality-of-care outcomes, the credibility/size of the Panel and the consistency of their performance over multiple Performance Years. A formula is used to calculate these factors and to derive an Outcome Incentive Award according to a matrix known to all Panels.

Understanding that 10 percent of CareFirst members account for 60 percent of the costs that we pay for health care services, and that nearly 80 percent of these patients suffer from multiple chronic conditions, the PCMH program is designed to enable physicians to closely coordinate care for the chronically ill, as well as help these patients better manage their diseases and improve their overall health.

The timing for today's Roundtable Discussion could not have been more appropriate. Just last week, CareFirst announced the results of its first full year of our PCMH initiative. With nearly 3,600 participating primary care providers, providing care for nearly a million of CareFirst's members, we believe CareFirst's PCMH program is the largest and one of the most ambitious of its kind anywhere in the nation. I am pleased to report that nearly 60 percent of eligible PCMH Panels (small teams of primary care physicians and nurse practitioners) earned increased reimbursements for their performance in 2011.

Increased reimbursements – or Outcome Incentive Awards (OIAs) – are based on a combination of savings achieved by a particular Panel against projected 2011 total care costs for CareFirst members as well as the attainment of quality points in the provision of care to a Panel's patients. OIAs will be paid to PCMH participants in the form of increased fee reimbursements for certain primary care services beginning July 1, 2012 and continuing through June 30, 2013.

The CareFirst PCMH is designed to improve health care quality while, over time, bending the cost curve. By providing incentives to primary care providers based on patient outcomes, promoting collaboration and integration between health care providers, and emphasizing coordinated care for the chronically ill, the PCMH is revolutionizing patient-centered care with unmatched support for the communities CareFirst serves.

The premise of our PCMH program is simple: let primary care providers (PCPs) serve as the “quarterback” of a team of health professionals to focus on providing coordinated care for those patients who need it most. Incentives to PCPs, including an immediate 12 percent increase in their fees as well as additional compensation for the development and monitoring of patient-specific care plans for their sickest patients, reinforce the central role of primary care in helping members manage their health risks as well as guide their care when they experience major

illness, especially involving chronic conditions such as coronary artery disease, congestive heart failure, diabetes, COPD, asthma and high blood pressure.

CareFirst's PCMH program enables collaboration between physicians, local nurses, and other health professionals to manage care. The team collaborates to initiate, more closely coordinate, and track care for the sickest of patients. In addition, the program facilitates implementation of Care Plans directed by primary care providers with the support of local community-based care teams (Care Coordination Teams) headed by RN Local Care Coordinators who arrange for and track the care of those members who are at highest risk or who would benefit most from a comprehensive Care Plan. As a result of collaboration and coordinated care, health care providers can take steps to keep patients healthier, and prevent chronic conditions from developing into even more serious health issues.

Providers are responding, with about 150 of the 250 eligible Panels earning Outcome Incentive Awards for the 2011 program year. The OIAs earned by Panels is based on both the level of quality and degree of savings achieved by the Panel's participating providers. While we are still in the early stages of an effort that requires new ways of delivering care, the first year of the program demonstrates to PCPs that we recognize the critical role they can play in improving care and meaningfully reducing costs over the long-term. We expect these incentives will motivate them even more to engage in the program and to focus on quality and reducing costs.

Let me share some highlights from the first year of the PCMH program:

1. Program participants (Panels) earning OIAs achieved an average 4.2 percent savings against expected 2011 care costs.
2. Program participants who did not earn OIAs registered costs that averaged 4 percent higher than expected for 2011.
3. On average, participants earning OIAs will see a 20 percent increase in their reimbursement levels, over and above the 12 percentage point increase paid to all participants that continue to remain in good standing in the PCMH program.

4. The cost of care for all CareFirst members attributed to PCMH participants was 1.5 percent lower than had been projected for 2011.
5. Quality scores for panels receiving an OIA and those not receiving an OIA were comparable.

In 2011, the PCMH program measured quality performance using nationally recognized measures for appropriate use of health care services and effectiveness of care. Panels also could earn quality points based on patient access (such as e-scheduling and extended office hours) and structural capabilities (including using e-prescribing and electronic medical records).

Since its launch in January 2011, the PCMH program has grown quickly and now includes about 80 percent of all eligible primary care physicians in CareFirst physician networks. In the first 18 months of the program, CareFirst has significantly enhanced the tools, resources, and supports available to PCMH participants. These enhancements include:

- A detailed online member health record and online care plan development tool available 24/7 via the internet.
- Comprehensive data on their CareFirst patient population to identify opportunities for care improvement and cost savings.
- Teams of registered nurses, community-based Local Care Coordinators and CareFirst Regional Care Coordinators, aligned with individual practices to help coordinate care for the sickest patients.
- A team of PCMH Program Consultants to help participants understand and utilize the tools and data available through the program.
- Free access to the American College of Physicians Medical Home Builder 2.0 tool to assist practices in transforming to a medical home model.
- Dedicated member service resources for CareFirst PCMH members.

The types of supports we have put in place have never been made available to primary care providers before and we are continuously refining and expanding these supports to meet the needs of PCPs and to achieve the long-term gains in quality and cost reduction that we believe are possible through PCMH.

Extending PCMH to the Health Safety Net and Medicare Populations

Recognizing the potential for significant improvements in overall health outcomes, through its *CareFirst Commitment* community giving program, CareFirst has committed to invest more than \$8.5 million in grants and other resources over three years to support health safety net clinics in our service area to create and/or enhance patient centered care to the region's most vulnerable populations.

We also have an application pending to partner with the Centers for Medicare and Medicaid Services (CMS) to extend the PCMH program to Medicare beneficiaries in parts of our market service area. If accepted, this single-payer program would become a two-payer public-private cooperative program that we believe has the potential to move the region toward a new health care financing model that uses the incentives inherent in a global capitation model to counteract the volume-inducing aspects of fee for service, but without shifting risk to PCPs who are not in a position to assume those risks. It is also intended to move the region toward an all-payer model that starts with the two largest payers – Medicare and CareFirst.

We believe placing Medicare and CareFirst in a single, common model will help CMS achieve its goals of higher quality, improved outcomes and lower costs. Together, CareFirst and Medicare account for well over half of the region's health care spending. Should our grant proposal be accepted and it proves successful, it can be expanded to include other payers based on a PCP-focused common provider network and incentive model supported by high touch/locally based nurse-led care transition and coordination teams. These teams would take advantage of a newly created web-based patient tracking, reporting, care management and analytics system that has been developed specifically for this purpose and is the underpinning of CareFirst's existing PCMH program.